MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address RS Medical PO Box 872650 VanCouver WA 98687-2650	MDR Tracking No.: M4-03-7336-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 1 TX Public School WC Pro c/o Creative Risk Funding PO Box 203668 Austin TX 78720-3668	Date of Injury: Employer's Name: Magnolia ISD Insurance Carrier's No.: 01074918

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
1/21/03	**3/23/03**	**E1399**	**$500.00**	**$500.00**

PART III: REQUESTOR'S POSITION SUMMARY

Undated: "Statement of Disputed Issue –(i) Rental of RS41…a combination 4 channel muscle stimulator/interferential device…(ii) Payment has been denied…(iii) TWCC…134.600 (h) states preauthorization for DME…required if the total exceeds $500.00…"

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent did not respond to MDR.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

HCPCS code E1399 (DME 4ch monitor combo) denied with "A –cumulative DME billing of $500.00 requires Preauthorization. No additional payment recommended."

The respondent did not submit convincing evidence per rule 133.307, that the RS-41 rental exceeded the $500.00. According to the information for review, the requestor did not bill in excess of Rule 134.600(h)(11) therefore reimbursement is recommended. ($250.x 2 months = $500.00)

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $500.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

	Carol Lawrence	03/31/05
Authorized Signature	Typed Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____